ment's response be if the results of these experiments are positive: an extension of the initiatives?

In all cases an international discussion is desirable.

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Legalisation would have to be accompanied by personal responsibility

EDITOR,—Richard Smith argues for the legalisation of those psychoactive substances whose distribution or possession is currently a crime.¹ The argument is presented in terms of the impossibility of stopping people from wanting to take illicit drugs, the failure of prohibitionist policies, the desirability of a reduction in the costs of enforcement, the possibility of education about drugs, the attraction of purer preparations of drugs being manufactured by large companies, and the right of individuals to do what they like so long as no harm is done to others.

All drugs, including alcohol and tobacco, harm the user. But it is the country as a whole that foots the bill for the care of people with illnesses caused by the consumption of drugs. Without this cost the taxes we pay would be considerably less. Drug users could well argue that they, too, contribute to the national coffers and that their taxes help to pay for the treatment of other people's illnesses. The issue here is one of proportion.

The use of every drug also entails harm to others: passive smoking causes disability and death in non-smokers, dependence on alcohol disrupts family life, a considerable proportion of road traffic and other accidents are related to alcohol, and people with drug induced psychoses have killed or seriously injured others. Dependent users desperate for supplies of their drugs commit serious crimes, including murder. We are a long way from the situation in which what drug users do in private does no harm to others.

If currently illicit psychoactive substances were legalised we would not incur the costs of enforcement, prosecution, and imprisonment but we would still have the personal and financial costs of the care of people with drug induced disorders, prosecution for crimes committed under the influence of drugs, and serious harm to others. Decriminalisation would therefore have to be accompanied by a clear statement of drug users' personal responsibility for the consequences of their self poisoning.

The government has no right to prevent people from consuming anything, but it has a responsibility to inform everyone of the harmful effects of what is consumed. Drug and alcohol treatment and rehabilitation services will always be available to those who seek help, but it has to be made abundantly clear that any harm caused to others in the search for, or use of, drugs must be punished.

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Harm minimisation is a way of lessening effects of more harmful drugs

EDITOR,—I hope that Richard Smith's editorial on the prohibition of drugs and the potential solutions provided by (partial) legislation¹ will stimulate the debate in Britain, which has been extraordinarily slow to evolve. While this delay has been partially due to political gagging and the reluctance of academics to take sides in a controversial area of policy, another problem exists, which is exemplified by the editorial—namely, confusion over the drugs that may or may not be dangerous and the tendency to refer to drug abuse, use, and misuse as if they all concerned the same substance. As a recent contribution in a national newspaper identified, in one word (drugs) we include all illicit substances and the treatments and cures for many diseases.²

To take the debate forward, research needs to provide separate information about those drugs that may be less harmful, especially cannabis, and to remove them from the debate about more harmful and less well understood drugs. A similar division needs to be acknowledged between the harmful effect of substances themselves and of the circumstances of their administration or mode of use. Smoking heroin must be infinitely less harmful than injecting it. At various times the Edinburgh drug addiction study has identified that in Edinburgh more than 50% of people who inject heroin have HIV infection, over 60% have evidence of past infection with hepatitis B virus, and (most recently and most significantly for the future) 70% have antibodies to hepatitis C virus.

With better research into drugs of misuse it might become clear that in many instances the drug itself is not particularly toxic but the circumstances of its use and the mode of its administration can be lethal. If cannabis is taken out of the debate then the concept of harm minimisation or risk reduction might be seen as the way to lessen the dangerous effects of opiates, amphetamines, and other drugs. If it were possible to remove the effects of poverty and unemployment then the damage done by drugs would be seen in an even clearer perspective. If the resources given to law enforcement and the costs of custodial and other sentences were channelled into community services (medical and other support) then the drugs war might disappear completely.

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Legalisation would be likely to result in increased use

EDITOR,—I strongly disagree with the numerous assertions by Richard Smith that legalising or decriminalising drugs is the answer to the drug problem.¹ The first major misconception is that legalisation or decriminalisation would result in an overall decrease in the problems associated with drug use. As DuPont and I pointed out in our detailed consideration of drug policy, any reduction in the intensity of drug policy is likely to result in an increase in drug use and associated problems.² An excellent example of this is the drastic difference in the use of marijuana compared with the use of alcohol and tobacco among adolescents. These drugs are all illegal for young people, yet the legal drugs are far more heavily used.

Dutch drug policy is an excellent example of misguided drug policy. While Smith's editorial discusses drug use in the Netherlands until 1985, drug use among Dutch males aged 12-18 increased 277% from 1984 to 1992, and the number of users

of marijuana rose 50% from 1991 to 1993.³ Crime has increased drastically, with shootings increasing by 40%, car thefts by 62%, and robberies by 69%.⁴ That is understandable, since in the United States about half of violent crimes are committed under the influence of drugs.⁵

The reality that we face in the United States and elsewhere is that we have only partially fought a drug war. We need to bolster efforts to prevent drug use and to broaden the availability of treatment. In addition, we should put teeth into prohibition and imprisonment. Drug dealers deal their drugs with minimal fear of imprisonment. Federal inmates imprisoned for trafficking in marijuana possessed on average 3.6 tonnes, while those imprisoned for trafficking in cocaine possessed on average 83 kg. We should consider even more stringent penalties for high level dealers and move towards pressuring casual users to refuse drugs through the use of drug testing and intervention.

Lastly, all of us need to sing from the same hymnal. Internationally, so many people are heading in so many directions that the public does not know whom to follow. It is particularly important that prestigious medical journals do not lead the public down a harmful road by proposing legalisation or decriminalisation.

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The aim should be a drug free society

EDITOR,—The image of drug use in the Netherlands depicted in Richard Smith's editorial does not reflect the true situation.¹ The note on Dutch drug policy recently sent to parliament by the Dutch government estimated the number of regular users of cannabis as being 675 000—that is, 4.5% of our population of 15 million.²

In 1980 there were a few dozen so called coffee shops, where the sale of cannabis is tolerated under certain conditions. Today, according to the government's note, the number of coffee shops and illegal 'sale points' is estimated at over 2000. The note states that the sale of cannabis in many municipalities has expanded enormously in the 1980s and '90s and that the number of coffee shops and the resulting nuisance have increased. Initially these shops were situated in a few large towns, but now they are spread throughout the country.

According to an investigation by the National Institute for Alcohol and Drugs, which is sponsored by the government, from 1984 to 1992 the use of cannabis among 12-19 year old pupils almost trebled (lifetime prevalence from 4.8% to 13.6%, use in the past month from 2.3% to 6.5%).³ Walburg, the director of the Jellinek Centre (an institute in Amsterdam that helps drug users) has said that the growing number of coffee shops has lowered the threshold for experimenting with hard drugs and that the increase in young heroin users is now alarming.⁴

We must certainly look for the best way to deal with the drug problem. As all illicit drugs are harmful we should set ourselves a target for a drug free society. This may seem utopian, but it is the only way. Toleration is not merciful, but prevention and cure are. A good drug policy should have four aspects, two related to prevention

and two related to relief. Firstly, good information should be given to parents, schools, and children and should include the dangers of cannabis (memory impairment, the fact that it contains more carcinogens than tobacco, etc). Secondly, drugs should be eliminated. The police are on the right track in the way that they tackle big dealers, but they should be allowed to tackle street dealing as well, because it is difficult to find drugs when petty sales are reduced.³ Thirdly, users should be able to gain admission to drug free institutions where they are treated with respect and encouragement so that they can regain their self respect. Finally, good aftercare is necessary: any former user should have a counsellor, who could help him or her find accommodation and a job. Weekly urine checks are advisable so that any relapse can be recognised.

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Evaluating new surgical procedures

Hip replacements come in at least 10¹¹ varieties

EDITOR,—I strongly support Ian Russell's call for collaboration between surgeons and trialists.¹ Russell makes many important points, but three additional questions should also be asked when surgical procedures are being evaluated: which?, how?, and when? These are particularly relevant to surgery for trauma and in orthopaedics. An example is total hip replacement operations. Not all such procedures are the same; there is no practised consensus on hardware or method.²

Which?—At least 62 different total hip replacements are available in Britain.³ Many are modular, permitting the use of different sizes of femoral head with different materials at the surgeon's discretion, which allows further multiple variation.

How?—In the past six years I have worked for 17 consultant orthopaedic surgeons, who have all used a different, unique method for total hip replacement operations. The table shows the number of possible variations at various stages that I have learnt. The sum of the variations is 1.08×10¹¹. This is a conservative, theoretical estimate of the number of possible methods in total hip replacement operations. Each variation at each stage could alter the final outcome.

When?—A good result at five years does not always mean a good result at 20 years. The randomised controlled trial in surgery is the utopian

ideal that will provide evidence based surgery. This is the goal to which all surgeons should strive, though the challenge is enormous.

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Design of trials should depend on whether new skills are required

EDITOR,—We agree with Ian Russell¹ that the randomised trial is the design of choice for evaluating surgical procedures; this view has been reinforced by others.² Nevertheless, new surgical procedures should be studied in the context of the skills required to achieve them. If a new procedure requires the acquisition of new skills then the learning curve ought to be assessed. On the other hand, if the procedure is conceptually a new approach to a disease but requires traditional surgical skills then experienced surgeons ought to perform it; then it should be possible to randomise the first patient who undergoes the new procedure. Once a technique has been established as safe and effective and its widespread impact and efficacy are being studied it may be widely disseminated, but compulsory audit is essential.

Russell deems the blinding of patients and carers in randomised controlled trials to be irrelevant and impractical. If media publicity has imbued the minds of patients and carers with the advantages³ or dangers⁴ of a new operation then blinding becomes highly relevant. In practice, blinding patients and carers is not as difficult as people might think (AWM *et al*, annual conference, Harrogate, 20-22 April 1994). The use of multiple centres in such trials also needs to be carefully considered because, although recruitment is facilitated, the trials necessarily become loosely controlled.

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Few trials of laparoscopic cholecystectomy have been randomised

EDITOR,—We agree with Ian Russell that the randomised trial is the design of choice for evaluating new surgical procedures.¹ Russell points out

that there have been only about 10 trials comparing laparoscopic with conventional cholecystectomy but is incorrect in implying that these were all randomised trials and that only one randomised more than 100 patients.²

So far as we are aware there have been only three prospective randomised trials, two of which contained more than 100 patients. The first trial randomised 70 patients in five hospitals between eight surgeons in Canada,³ while the second randomised 299 patients in five hospitals between seven surgeons in Glasgow and Kilmarnock.⁴ Our series randomised 310 patients between one consultant surgeon and his trainee senior registrars and associate specialist on one surgical team in one hospital trust group.⁵

Russell does not mention one of the main problems that we have met in trying to publish our work, which has been the resistance of the already converted enthusiasts to any suggestions that the new procedure may not be as good as the experts suggest. Claims have been made that laparoscopic cholecystectomies are possible in 95-96% of cases, with the natural implication, therefore, that any surgeon not able (or willing) to achieve these figures must be untrained, unskilled, or, indeed, unsuited to the new technique.

The only way in which an ideal trial could be conducted would be for patients (unselected, of course) to be randomised by an independent agency and then referred to surgeons 1 and 2, who would be the recognised experts in each particular technique. The next best method would be for one surgical team or one surgeon, equally enthusiastic about both techniques and open minded and unbiased about the outcome, to be responsible for the whole trial. Multicentre trials are open to much hidden bias and unwitting selection and so are not as helpful to determine the true differences between procedures.

The series quoted by Russell as having more than 100 patients² was part of the Scottish series, in which 132 patients were randomised at five different hospitals (interestingly, between only six consultant surgeons at that stage in 1993).

In these prospective trials it is interesting to note that the rate of conversion from laparoscopic to open cholecystectomy is about 10%.

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Table 1—Possible options in total hip replacement surgery

Stage of procedure	Possible variations	Stage of procedure	Possible variations
Theatre environment	3	Acetabular preparation	6
Patient's position	3	Acetabular cementing technique	3
Skin preparation	4	Femoral preparation	8
Patient draping	6	Distal cement plug	2
Surgeon's gown	9	Femoral cementing technique	4
Skin drape	3	Closure	2
Towels	2	Antibiotic prophylaxis	3
Approach	7	Thromboembolic prophylaxis:	
Tray system	2	Chemical	4
Power instruments	2	Physical	4
Irrigation	3		

Treatment of acute anaphylaxis

Letters contained errors of logic

EDITOR,—The letters¹ about my article on acute anaphylaxis² show the difficulties of trying to provide simple algorithms when controlled trials are impossible and the pattern of symptoms and severity vary. Some of the replies contain errors of logic.

Glenis K Scadding emphasises the use of tourniquets to avoid further contact with the allergen. Such use is not supported by data and may be hazardous as release of arterial tourniquets pro-